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IRO Certificate

## **Notice of Independent Review Decision**

July 2, 2008/ July 29, 2008 (Amended 8/4/08 to change error date from July 2, 2008 to July 29<sup>th,2008</sup>).

**DATE OF REVIEW:** JULY 29, 2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

L4-5 and L5-S1 lumbar laminectomy (hemilaminectomy) discectomy with decompression, microdissection, discography, lateral arthrodesis, posterior non-segmental bone graft, posterior non –segmental instrumentation, anterior lumbar arthrodesis

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Neurological Surgery

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

**X Upheld** (Agree)

**Overtaken** (Disagree)

**Partially Overtaken** (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY (SUMMARY):**

This case involves a male who in xx/xx was pulling a device when he developed low back pain. Conservative treatment was unsuccessful in dealing with his trouble, and an April 2002 MRI suggested L4-5 and L5-S1 disk bulging with thecal sac impingement.. On 3/19/04 a left-sided L4-5 hemilaminectomy with disk removal was carried out. No report of the procedure was provided. The patient was initially helped by this procedure, but had recurrent pain in late 2004, and repeat MRI on 12/29/04 showed significant scarring with nerve root entrapment at the L4-5 level on the left. The patient's continued discomfort has interfered with his work, and he continues to have this discomfort despite rest and considerable medications. The patient's last lumbar MRI on 5/2/08 shows a mild central disk protrusion at L5-S1 and post-operative scarring at the L4-5 level. There is nothing on this report or examination, or any other reports provided for this review to suggest a documentation of instability in the lumbar spine.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

I agree with the benefit company's decision to deny the requested extensive operative procedure. If there were a study, such as CT myelography, documenting Dr. assessment of "failed lumbar spine syndrome," instability and HNP at L5-S1, with instability at L4-5 with failed conservative treatment over three years, then disagreement with the denial would be indicated. However, without a study to document the necessity for the extensive procedure that is proposed, I agree with the denial of the procedure.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

**X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN**

**ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**MILLIMAN CARE GUIDELINES**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**TEXAS TACADA GUIDELINES**

**TMF SCREENING CRITERIA MANUAL**

**PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**